Whenever there is compulsory treatment or detention there must be an independent and neutral body of appeal for regular inquiry into these cases. Every patient must be informed of its existence and be permitted to appeal to it, personally or through a representative, without interference by the hospital staff or by anyone else.

7 The psychiatrist must never use the possibilities of the profession for maltreatment of individuals or groups, and should be concerned never to let inappropriate personal desires, feelings or prejudices interfere with the treatment.

The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to scientific or ethical principles the psychiatrist must refuse to co-operate. When, for any reason, either the wishes or the best interests of the patient cannot be promoted, he or she must be so informed.

8 Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient releases the psychiatrist from professional secrecy, or else vital common values or the patient's best interest makes disclosure imperative, In these cases, however, the patient must be immediately informed of the breach of secrecy.

9 To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case history is published, and all reasonable measures be taken to preserve the anonymity and to safeguard the personal reputation of the subject.

In clinical research, as in therapy, every subject must be offered the best available treatment. His or her participation must be voluntary, after full information has been given of the aims, procedures, risks and inconveniences of the project, and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study.

For children and other patients who cannot themselves give informed consent this should be obtained from someone close to them.

10 Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research programme in which he or she participates. This withdrawal, as well as any refusal to enter a programme, must never influence the psychiatrist's efforts to help the patient or subject.

The psychiatrist should stop all therapeutic, teaching or research programmes that may evolve contrary to the principles of this Declaration.

Commentary

Clarence D D Blomquist
Karolinska Institute, Stockholm, Sweden

When the World Psychiatric Association asked me, early in 1976, to draft an international code of ethics for psychiatry, the Declaration of Hawaii, I was a visiting scholar at the Institute of Society, Ethics and the Life Sciences in Hastings-on-Hudson, New York. In this stimulating and really scholarly atmosphere I had become aware of the sometimes diverse approaches to medical ethics and the physician/patient relationship in Europe and the US[1]. In Europe we stick to the Oath of Hippocrates, and our ethic rests on a benevolent paternalism. We really care for our patients, but nothing of the decision is left to them. The doctor takes over all responsibility. In the US medical ethics is more connected to the Constitution than to Hippocratic ethic and one speaks in terms of constitutional or human rights. Medical decisions rest more with the patient or his/her legal proxy. Ethics becomes a branch of law and this often leads to bureaucracy and a frequent suing of the doctor for malpractice.

My endeavour when drafting the Declaration was to avoid these extremes and find some balance in between. I tried to gain more concern for the patients' autonomy and right to participate in decisions about their own lives and health but to avoid a rigid legalistic system and to give place for man's legitimate need for trust, confidence and care.

The relationship between the patients and their psychiatrists then becomes an agreement between two autonomous parties, requiring 'trust, confidentiality, openness, co-operation and mutual responsibility'. So the aim of psychiatry could be said to be to promote not only health but also 'personal autonomy and growth'.

But is there really need for a code of ethics for psychiatry? Yes, I think so. Psychiatry has many specific features and problems unknown or at least less evident in other branches of medicine, and I hope most of them are covered by the Declaration. Our Russian colleagues are said to misuse psychiatry for political reasons. This type of misuse is well covered by the paragraphs 5 to 7. But there are other kinds of misuse and other ethical problems in psychiatry today.

We doctors, psychiatrists or not, no longer go on declaring our sole duty being towards the present patient. We have, and we are getting more and more, conflicting loyalties; towards the patient, presumptive patients, society and the common good.

The great problems I find, however, not in involuntary treatment and incarceration, but in the inordinate spreading of different psychotherapies, some reasonable and good, some less so, and the

soon total psychiatrisation of everybody and everything. This is not to show respect for personal autonomy and integrity. In the holy name of mental health we feel entitled if not obliged to force 'therapy' on people who never asked for any and people are reified and reduced to a computer programmed according to Freud, Janov or some other holy and unquestionable guru.

Another problem is the widespread amateurism in psychotherapy. Anyone seems to feel a calling to practice it without adequate knowledge and training. As to group-psychotherapy, it has become so fashionable that more than ordinary strength is needed to resist the social pressure to enter a group and in all kinds of psychotherapy and milieu-therapy too little respect is shown for the autonomy of the person concerned.

Problems of a similar kind are of course also found in behaviour therapy and modification, in drug therapy, psychosurgery etc and it seems to me that in most psychiatric treatment there is a risk for addiction and 'hospitalisation', not least in psychotherapy and modern therapeutic communities, which often offer a care so nice and comfortable that they badly fit the aim to prepare the patients for a life of their own in a world with little of the comfort of the therapeutic situation.

These are some of the considerations I made while drafting the Declaration. I tried to avoid details, would rather give some general rules or a specific approach to psychiatry and the therapeutic relationship to make the psychiatrist aware of the ethical problems and traps of his profession and to help him find the ethically correct way of dealing with his job and his patients.

Elsewhere[2] I have pointed out more in detail the differences between the Declaration of Hawaii and the Oath of Hippocrates and other codes and declarations with the Oath as their philosophical foundation.

References

[1]Blomquist, C D D (1976). A New Era in European Medical Ethics. *Hastings Center Report*, **6**, 2: 7–8.

[2]Blomquist, C D D (1977). From the Oath of Hippocrates to the Declaration of Hawaii. *Ethics in Science & Medicine*, 4, 139–149.